		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042499

Facility Name: MCKINLEY COURT

Address: 500 WEST MCKINLEY AVE. (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (217) 875-0020 **Fax #** (217) 875-9434

IDPA ID Number: 36-4121313

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,165	3,231	8,178	17,574	8
9	SNF/PED					9
10	ICF	19,644	12,945	523	33,112	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,809	16,176	8,701	50,686	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.32%

D. How many bed-hold days during this year were paid by Public Aid?
8 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 7,588

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	255,121	36,732	9,948	301,801		301,801	(3,122)	298,679			1
2	Food Purchase		200,998		200,998		200,998	(1,602)	199,396			2
3	Housekeeping	201,394	31,570		232,964		232,964	(1,087)	231,877			3
4	Laundry	85,827	41,101	381	127,309		127,309	(285)	127,024			4
5	Heat and Other Utilities			130,399	130,399		130,399		130,399			5
6	Maintenance	84,765	26,990	34,950	146,705		146,705	(355)	146,350			6
7	Other (specify):*			19,793	19,793		19,793		19,793			7
8	**TOTAL General Services**	627,107	337,391	195,471	1,159,969		1,159,969	(6,451)	1,153,518			8
	B. Health Care and Programs											
9	Medical Director			34,230	34,230		34,230		34,230			9
10	Nursing and Medical Records	1,607,809	152,857	66,844	1,827,510		1,827,510	(36,882)	1,790,628			10
10a	Therapy	81,756		1,486	83,242		83,242		83,242			10a
11	Activities	108,601	2,523	11,871	122,995		122,995	(1,040)	121,955			11
12	Social Services	23,231		2,852	26,083		26,083		26,083			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,821,397	155,380	117,283	2,094,060		2,094,060	(37,922)	2,056,138			16
	C. General Administration											
17	Administrative	78,106		553,654	631,760		631,760	(530,482)	101,278			17
18	Directors Fees											18
19	Professional Services			327,750	327,750		327,750	(163,116)	164,634			19
20	Dues, Fees, Subscriptions & Promotions			84,322	84,322		84,322	(46,183)	38,139			20
21	Clerical & General Office Expenses	118,079	28,432	58,264	204,775		204,775	138,210	342,985			21
22	Employee Benefits & Payroll Taxes			469,560	469,560		469,560		469,560			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,908	6,908		6,908	8,522	15,430			24
25	Other Admin. Staff Transportation			6,635	6,635		6,635		6,635			25
26	Insurance-Prop.Liab.Malpractice			131,444	131,444		131,444	33,964	165,408			26
27	Other (specify):*			12,000	12,000		12,000	(12,000)				27
28	**TOTAL General Administration**	196,185	28,432	1,650,537	1,875,154		1,875,154	(571,085)	1,304,069			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,644,689	521,203	1,963,291	5,129,183		5,129,183	(615,458)	4,513,725			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,948	
	REPAIRS & MAINTENANCE		0	
			0	9,948
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		381	
			0	381
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,085	
	ELECTRICITY		87,222	
	WATER		8,092	
	CABLE TV - LOBBY		0	
			0	130,399
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,002	
	PAINTING & DECORATING		4,105	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		13,042	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		7,335	
	FIRE SERVICE		3,466	
			0	
			0	
			0	34,950
7	**OTHER**			
	SCAVENGER		19,793	
	SECURITY SERVICE		0	19,793
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	34,230	34,230

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,200	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	64,444	
			0	
			0	66,844
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		878	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		608	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,486
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		9,019	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,852	
			0	11,871
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,852	
			0	2,852
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	553,654	553,654
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	32,127	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	295,623	
			0	327,750
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	14,109	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	20,991	
	EMPLOYEE WANT ADS	XIX F	19,195	
	CONTRIBUTIONS	VI 20 XIX F	180	
	DUES & SUBSCRIPTIONS	XIX F	15,681	
	LICENSES & PERMITS	XIX F	660	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	6,527	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,215	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,764	84,322
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		5,674	
	EQUIPMENT REPAIR & MAINTENANCE		7,381	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	244	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		42,357	
	MESSENGER SERVICE		2,608	
			0	58,264

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	198,552	
	UNEMPLOYMENT COMPENSATION	XIX D	33,532	
	WORKERS COMPENSATION INSURANCI	XIX D	61,432	
	HOSPITALIZATION INSURANCE	XIX D	153,399	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,206	
	EMPLOYEE PHYSICAL EXAMS	XIX D	5,207	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	10,232	
	CHICAGO HEAD TAX	XIX D	0	469,560
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	5,827	
	TRAVEL	XIX G	1,081	
			0	
			0	6,908
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,635	6,635
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		131,444	131,444
27	**OTHER**			
	BAD DEBTS	VI 24	12,000	
				12,000

GRAND TOTAL COLUMN 3 OTHER 1,963,291

MCKINLEY COURT
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	200,998	PATIENT MEALS	152058
LESS SALES TAX	(1,602)	ADD EMPLOYEE MEALS	0
NET FOOD	199,396	TOTAL MEALS/YEAR	152058
TOTAL PATIENT CENSUS	50,686	NET FOOD	199396
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	152058
TOTAL PATIENT MEALS	152058	COST PER MEAL	1.31
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number MCKINLEY COURT #0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			171,767	171,767		171,767	129,582	301,349			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,752	127,752		127,752	298,955	426,707			32
33	Real Estate Taxes			81,119	81,119		81,119		81,119			33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(545,736)	30,264			34
35	Rent-Equipment & Vehicles			22,140	22,140		22,140	8,593	30,733			35
36	Other (specify):* STORAGE			6,770	6,770		6,770		6,770			36
37	**TOTAL Ownership**			985,548	985,548		985,548	(108,606)	876,942			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		209,354	444,922	654,276		654,276		654,276			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		209,354	527,272	736,626		736,626		736,626			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,644,689	730,557	3,476,111	6,851,357		6,851,357	(724,064)	6,127,293			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(130,221)	30		9
10	Interest and Other Investment Income	(123,633)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,602)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(244)	21		18
19	Entertainment	(14,109)	20		19
20	Contributions	(5,395)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(20,991)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,527)	20		28
29	Other-Attach Schedule	(16,288)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (331,010)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(393,054)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (393,054)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (724,064)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MCKINLEY COURT

ID# 0042499

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2323	6	1
2	VACATION ACCRUAL	(3,122)	1	2
3	VACATION ACCRUAL	(1,087)	3	3
4	VACATION ACCRUAL	(285)	4	4
5	VACATION ACCRUAL	(2,678)	6	5
6	VACATION ACCRUAL	(8,396)	10	6
7	VACATION ACCRUAL	(1,040)	11	7
8	VACATION ACCRUAL	2,564	17	8
9	VACATION ACCRUAL	(4,567)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,288)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(3,122)	0	0	0	0	0	0	0	0	0	0	(3,122)	1
2	Food Purchase	(1,602)	0	0	0	0	0	0	0	0	0	0	(1,602)	2
3	Housekeeping	(1,087)	0	0	0	0	0	0	0	0	0	0	(1,087)	3
4	Laundry	(285)	0	0	0	0	0	0	0	0	0	0	(285)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(355)	0	0	0	0	0	0	0	0	0	0	(355)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,451)	0	0	0	0	0	0	0	0	0	0	(6,451)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(8,396)	0	(11,790)	0	(16,696)	0	0	0	0	0	0	(36,882)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,040)	0	0	0	0	0	0	0	0	0	0	(1,040)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,436)	0	(11,790)	0	(16,696)	0	0	0	0	0	0	(37,922)	16
	C. General Administration													
17	Administrative	2,564	0	(266,074)	(200,229)	0	0	(66,743)	0	0	0	0	(530,482)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,763	(50,268)	32,647	513	(153,771)	0	0	0	0	0	(163,116)	19
20	Fees, Subscriptions & Promotions	(47,022)	0	468	152	15	204	0	0	0	0	0	(46,183)	20
21	Clerical & General Office Expenses	(4,811)	0	42,925	17,832	1,101	81,163	0	0	0	0	0	138,210	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,105	279	2,041	2,097	0	0	0	0	0	8,522	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	28,716	2,035	518	1,256	1,439	0	0	0	0	0	33,964	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	**TOTAL General Administration**	(61,269)	36,479	(266,809)	(148,801)	4,926	(68,868)	(66,743)	0	0	0	0	(571,085)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,156)	36,479	(278,599)	(148,801)	(11,770)	(68,868)	(66,743)	0	0	0	0	(615,458)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCKINLEY COURT # 0042499 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(130,221)	253,888	3,036	0	100	2,779	0	0	0	0	0	129,582	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(123,633)	422,588	0	0	0	0	0	0	0	0	0	298,955	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(576,000)	13,195	0	884	16,185	0	0	0	0	0	(545,736)	34
35	Rent-Equipment & Vehicles	0	0	3,349	2,184	1,406	1,654	0	0	0	0	0	8,593	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(253,854)	100,476	19,580	2,184	2,390	20,618	0	0	0	0	0	(108,606)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(331,010)	136,955	(259,019)	(146,617)	(9,380)	(48,250)	(66,743)	0	0	0	0	(724,064)	45

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		MCKINLEY AVENUE, LLC		
OWNERS		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED BUSINESS		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 576,000	MCKINLEY AVE, LLC		$	$ (576,000)	1
2	V	19	ACCOUNTING FEES		" "		7,500	7,500	2
3	V	19	PROFESSIONAL FEES		" "		263	263	3
4	V	26	MORTGAGE INSURANCE		" "		28,716	28,716	4
5	V	30	DEPRECIATION - BLDG/IMP		" "		199,888	199,888	5
6	V	30	DEPRECIATION - EQPT		" "		54,000	54,000	6
7	V	32	AMORTIZATION - MTG COST		" "		4,347	4,347	7
8	V	32	INTEREST - MORTGAGE		" "		418,241	418,241	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 576,000			$ 712,955	$ * 136,955	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 16,613	FHC ENTERPRISES, INC.		$ 4,823	$ (11,790)	15
16	V	17	ADMINISTRATIVE	286,682	SHAEL BELLOWS OWNS 50% OF THIS FACILITY		20,608	(266,074)	16
17	V	19	PROFESSIONAL FEES	50,549	AND 100% OF FHC ENTERPRISES		281	(50,268)	17
18	V	20	DUES & SUBSCRITIONS		" "		468	468	18
19	V	21	CLERICAL		" "		42,925	42,925	19
20	V	24	TRAVEL		" "		4,105	4,105	20
21	V	26	INSURANCE		" "		2,035	2,035	21
22	V	30	DEPRECIATION		" "		3,036	3,036	22
23	V	34	RENT		" "		13,195	13,195	23
24	V	35	RENT-EQPT & VEH		" "		3,349	3,349	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 353,844			$ 94,825	$ * (259,019)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	YORK MANAGEMENT ASSOCIATES, INC.		$ 32,647	$ 32,647	15
16	V	20	DUES & SUBSCRIPTIONS		" "		152	152	16
17	V	21	CLERICAL		" "		17,832	17,832	17
18	V	24	TRAVEL		" "		279	279	18
19	V	26	INSURANCE		" "		518	518	19
20	V	35	RENT - EQPT & VEH		" "		2,184	2,184	20
21	V	17	ADMINISTRATIVE	200,229	" "			(200,229)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 200,229			$ 53,612	$ * (146,617)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 47,830	CARLYLE NURSING ASSOCIATES, LLC		$ 31,134	$ (16,696)	15
16	V	19	PROFESSIONAL FEES		" "		513	513	16
17	V	20	DUES & SUBSCRIPTIONS		" "		15	15	17
18	V	21	CLERICAL		" "		1,101	1,101	18
19	V	24	TRAVEL		" "		2,041	2,041	19
20	V	26	INSURANCE		" "		1,256	1,256	20
21	V	30	DEPRECIATION		" "		100	100	21
22	V	34	RENT		" "		884	884	22
23	V	35	RENT - EQPT & VEH		" "		1,406	1,406	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 47,830			$ 38,450	$ * (9,380)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 158,028	THE KENSINGTON GROUP, LLC		$ 4,257	$ (153,771)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		204	204	16
17	V	21	CLERICAL		" "		81,163	81,163	17
18	V	24	TRAVEL		" "		2,097	2,097	18
19	V	26	INSURANCE		" "		1,439	1,439	19
20	V	30	DEPRECIATION		" "		2,779	2,779	20
21	V	34	RENT		" "		16,185	16,185	21
22	V	35	RENT - EQPT & VEH		" "		1,654	1,654	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 158,028			$ 109,778	$ * (48,250)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 66,743	CHESTERFIELD, LLC		$	$ (66,743)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,743			$ 0	$ * (66,743)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY -								$		1
2	SHAEL BELLOWS	MNGMT CNSLT	ADMIN.	50%	SEE ATTACHED	0.31	2.01	SALARY	20,608	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,608		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FIRST HEALTH CARE ASSOCIATES
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	245,034	9	$ 46,961	$ 46,961	25,164	$ 4,823	1
2	17	ADMINISTRATIVE	DIRECT COST	1	1	20,608	20,608	1	20,608	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	245,034	9	2,739		25,164	281	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	245,034	9	4,554		25,164	468	4
5	21	CLERICAL	PATIENT DAYS	245,034	9	99,460		25,164	10,215	5
6	21	CLERICAL	DIRECT COST	1	1	32,710	32,710	1	32,710	6
7	24	TRAVEL	PATIENT DAYS	245,034	9	39,971		25,164	4,105	7
8	26	INSURANCE	PATIENT DAYS	245,034	9	19,813		25,164	2,035	8
9	30	DEPRECIATION	PATIENT DAYS	245,034	9	29,557		25,164	3,036	9
10	34	RENT	PATIENT DAYS	245,034	9	128,484		25,164	13,195	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	245,034	9	32,607		25,164	3,349	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 457,464	$ 100,279		$ 94,825	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: YORK MANAGEMENT ASSOC., LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSTIONAL FEES	PATIENT DAYS	83,958	4	$ 107,393	$	25,522	$ 32,647	1
2	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	83,958	4	500		25,522	152	2
3	21	CLERICAL	PATIENT DAYS	83,958	4	58,659	54,452	25,522	17,832	3
4	24	TRAVEL	PATIENT DAYS	83,958	4	918		25,522	279	4
5	26	INSURANCE	PATIENT DAYS	83,958	4	1,704		25,522	518	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	83,958	4	7,184		25,522	2,184	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 176,358	$ 54,452		$ 53,612	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOCIATES, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	234,229	9	$ 285,631	$ 285,631	25,522	$ 31,134	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	4,705		25,522	513	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	142		25,522	15	3
4	21	CLERICAL	PATIENT DAYS	234,229	9	10,102		25,522	1,101	4
5	24	TRAVEL	PATIENT DAYS	234,229	9	18,724		25,522	2,041	5
6	26	INSURANCE	PATIENT DAYS	234,229	9	11,520		25,522	1,256	6
7	30	DEPRECIATION	PATIENT DAYS	234,229	9	917		25,522	100	7
8	34	RENT	PATIENT DAYS	234,229	9	8,109		25,522	884	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	12,901		25,522	1,406	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 352,751	$ 285,631		$ 38,450	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	$ 39,055	$	25,522	$ 4,257	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	1,870		25,522	204	2
3	21	CLERICAL	PATIENT DAYS	234,229	9	744,608	660,461	25,522	81,163	3
4	24	TRAVEL	PATIENT DAYS	234,229	9	19,234		25,522	2,097	4
5	26	INSURANCE	PATIENT DAYS	234,229	9	13,205		25,522	1,439	5
6	30	DEPRECIATION	PATIENT DAYS	234,229	9	25,492		25,522	2,779	6
7	34	RENT	PATIENT DAYS	234,229	9	148,483		25,522	16,185	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	15,176		25,522	1,654	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,007,123	$ 660,461		$ 109,778	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - MCKINLEY AVE, LLC						$	$			$	1
2	GMAC MORTGAGE CORP.		X	MORTGAGE	$39,218.00	07/2002	6,375,000	6,254,647	07/2037	6.6600	418,241	2
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YEARS		152,161	140,603			4,347	3
4												4
5												5
	Working Capital											
6	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	2,678,528	DEMAND	VARIES	127,752	6
7												7
8												8
9	TOTAL Facility Related				$39,218.00		$ 7,002,161	$ 9,073,778			$ 550,340	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,002,161	$ 9,073,778			$ 550,340	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 70,404	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 75,347	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,943	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,176	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 81,119	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000	31,866	9
2001	4,976	10
2002	69,633	11
2003	75,347	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCKINLEY COURT COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042499

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-015	NURSING HOME	$ 75,347.44	$ 75,347.44
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,347.44	$ 75,347.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,100 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	119,700	1997	$	1
2					2
3	TOTALS	119,700		$	3

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1997		$ 4,688,282	$ 170,483	27.5	$ 170,483	$	$ 1,356,760	4
5			1997		10,762	391	27.5	391		2,919	5
6			1998		95,000	3,455	27.5	3,455		24,039	6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - MCKINLEY AVE, LLC										9
10	OUTDOOR SIGNS			1997	13,284	483	27.5	483		3,602	10
11	REPLACE, REPAIR AND SEAL PAVEMENT			1998	6,754	399	15	450	51	2,925	11
12	REPLACE BLACK VALLEYS			1999	5,875	214	27.5	214		1,167	12
13	WALLCOVERING/CARPETING/WINDOW TREATMENTS			1999	154,975	5,635	27.5	5,635		30,759	13
14	SPRINKLER SYSTEMS			1999	4,744	173	27.5	173		943	14
15	COURTYARD IMPROVEMENTS			1999	5,975	460	15	398	(62)	2,189	15
16	RESIDENT ROOMS/BATHROOMS - PAINTING			2000	13,710	498	27.5	498		2,222	16
17	FIRE ALARM CONTROL PANEL			2000	6,703	244	27.5	244		1,087	17
18	REMODELING - ARCHITECT FEE			2000	1,493	57	15	100	43	450	18
19	PAINTING - S/E CORRIDOR/SMOKING RM/NURSES STATIONS			2001	7,382	268	27.5	268		927	19
20	REPLACED 2 YORK ROOFTOP HVAC UNITS			2003	11,340	412	27.5	412		601	20
21	REMOVE & INSTALL 130 CUSTOM WINDOW TREATMENTS			2003	19,732	718	27.5	718		1,047	21
22	STENCIL & COAT LANDING DOCK & WALKWAY			2003	4,397	160	27.5	160		233	22
23	ROOF REPAIR - REPAIR AREA WITH BUCKLED SHEATING			2003	2,000	73	27.5	73		107	23
24	PREPARE & RESURFACE NORTH PARKING LOT			2003	5,120	186	27.5	186		268	24
25	DRAPES, WALLCOVERINGS & BORDERS-SOUTH CORRIDOR & L			2004	21,455	3,065	7	1,533	(1,532)	1,533	25
26	PREP, PAINT, HANG WALLCOVERINGS & BORDERS-PATIENT &			2004	58,800	8,400	7	4,200	(4,200)	4,200	26
27	DRAPES, CURTAINS, BORDERS & SIGNS - LOBBY, BEAUTY SHOP			2004	14,052	2,007	7	1,004	(1,003)	1,004	27
28	BOARD FOR BEHIND THE HANDRAILS - FRONT LOBBY			2004	1,585	36	27.5	36		36	28
29	LIGHTING FIXTURES AROUND THE OUTSIDE OF THE BUILDING			2004	3,335	76	27.5	76		76	29
30	DRAPES, VALANCE, RODS, HANDRAILS, & HANRAILS - PATIENT			2004	12,350	1,764	7	882	(882)	882	30
31	OAK UNFINISHED CABINETS AND BAY WINDOW TREATMENTS			2004	1,578	225	7	113	(112)	113	31
32	PREP & PAINT 26 BATHROOMS AFTER WALLPAPER REMOVAL			2004	3,800	543	7	271	(272)	271	32
33	REMOVE & DISPOSE ROOF BEHIND AIR CONDITIONER			2004	3,000	429	7	214	(215)	214	33
34	LAMINATED COUNTERTOP & SOLID SURFACE COUNTERS			2004	8,300	1,186	7	593	(593)	593	34
35	FURNITURE STORAGE WHILE REMODELING			2004	5,429	775	7	388	(387)	388	35
36	WIDEN TURNING RADIUS;PAVE PARKING LOT AND										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL SPEED BUMPS	2004	$ 15,150	$ 758	15	$ 505	$ (253)	$ 505	37
38	INSTALL VINYL SHEET FLOORING, CARPET HALLS	2004	80,244	11,463	7	5,732	(5,731)	5,732	38
39									39
40			ADJ TO SL	(15,148)			15,148		40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,286,606	$ 199,888		$ 199,888	$	$ 1,447,792	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 349,146	$ 33,944	$ 30,061	$ (3,883)	3-15 YRS	$ 144,470	71
72	Current Year Purchases	229,705	137,823	11,485	(126,338)	3-15 YRS	11,485	72
73	Fully Depreciated Assets	12,990					12,990	73
74	RELATED PARTY		59,915	59,915				74
75	TOTALS	$ 591,841	$ 231,682	$ 101,461	$ (130,221)		$ 168,945	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,878,447	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 431,570	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 301,349	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (130,221)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,616,737	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 18,762 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	2002 DODGE PICKUP	$ 281.46	$ 3,378	17
18					18
19					19
20					20
21	TOTAL		$ 281.46	$ 3,378	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MCKINLEY COURT STATE OF ILLINOIS # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 189,445	$		$ 189,445	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			43,167			43,167	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			209,554			209,554	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			2,756			2,756	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				160,136		160,136	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RENTALS, LAB, I.V. THERAPY Other (specify): X-RAY	39-2					49,218		49,218	13
14	TOTAL			$		$ 444,922	$ 209,354		$ 654,276	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 341,543	$ 423,015	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,254)	1,114,139	1,114,139	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,870	99,664	6
7	Other Prepaid Expenses	18,439	18,439	7
8	Accounts Receivable (owners or related parties)	245,116	10,000	8
9	Other(specify): ESCROW DEPOSITS		935,584	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,751,107	$ 2,600,841	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	2,950,666	2,950,666	11
12	Long-Term Investments	1,351	1,351	12
13	Land		841,622	13
14	Buildings, at Historical Cost		4,783,282	14
15	Leasehold Improvements, at Historical Cost		489,100	15
16	Equipment, at Historical Cost	578,850	1,118,850	16
17	Accumulated Depreciation (book methods)	(440,669)	(2,444,258)	17
18	Deferred Charges		140,603	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,090,198	$ 7,881,216	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,841,305	$ 10,482,057	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 342,764	$ 371,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,573	28,573	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,060	47,060	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,727	8,727	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,176	32
33	Accrued Interest Payable		34,713	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO DPA	16,350	16,350	36
37	MANAGEMENT FEES	5,305	5,305	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 448,779	$ 588,518	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,678,528	1,166,681	39
40	Mortgage Payable		6,254,647	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,678,528	$ 7,421,328	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,127,307	$ 8,009,846	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,713,998	$ 2,472,211	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,841,305	$ 10,482,057	48

*(See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,564,840	1
2	Restatements (describe):		2
3	ROUNDING ADJ	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,564,841	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	149,157	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 149,157	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,713,998	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,873,526	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,873,526	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,030	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,030	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	123,633	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 123,633	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	2,325	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,325	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,000,514	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,159,969	31
32	Health Care	2,094,060	32
33	General Administration	1,875,154	33
	B. Capital Expense		
34	Ownership	985,548	34
	C. Ancillary Expense		
35	Special Cost Centers	654,276	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,851,357	40
41	**Income before Income Taxes (line 30 minus line 40)****	149,157	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 149,157	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,990	2,049	$ 56,354	$ 27.50	1
2	Assistant Director of Nursing	1,920	2,123	50,089	23.59	2
3	Registered Nurses	15,844	16,724	317,517	18.99	3
4	Licensed Practical Nurses	24,679	26,702	421,521	15.79	4
5	Nurse Aides & Orderlies	72,586	77,360	723,584	9.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,322	5,974	81,756	13.69	8
9	Activity Director	3,847	4,123	65,550	15.90	9
10	Activity Assistants	5,242	5,748	43,051	7.49	10
11	Social Service Workers	1,815	2,020	23,231	11.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	13,103	13,863	136,267	9.83	14
15	Cook Helpers/Assistants	17,306	17,756	118,854	6.69	15
16	Dishwashers					16
17	Maintenance Workers	5,027	5,635	84,765	15.04	17
18	Housekeepers	21,638	23,505	201,394	8.57	18
19	Laundry	10,089	10,828	85,827	7.93	19
20	Administrator	2,231	2,565	78,106	30.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,251	9,095	118,079	12.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,381	3,535	38,744	10.96	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	214,271	229,605	$ 2,644,689 *	$ 11.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 9,948	1-3	35
36	Medical Director	120	34,230	9-3	36
37	Medical Records Consultant	12	1,200	10-3	37
38	Nurse Consultant	592	64,444	10-3	38
39	Pharmacist Consultant	216	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,852	11-3	44
45	Social Service Consultant	48	2,852	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,236	$ 116,726		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TOM MULLINS	ADMIN		$ 71,358
CINDY CRUMP	ADMIN		6,748
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 78,106

B. Administrative - Other

Description		Amount
RELATED PARTIES	MANAGEMENT FEES	$ 553,654
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 553,654

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		327,750
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 327,750

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 61,432
Unemployment Compensation Insurance		33,532
FICA Taxes		198,552
Employee Health Insurance		153,399
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		7,206
EMPLOYEE PHYSICAL EXAMS		5,207
PENSION/PROFIT SHARING PLANS		10,232
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 469,560

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,195
Health Care Worker Background Check	1,764
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	41,627
TRUST/FRANCHISE/CONTRIB/ETC	5,395
LICENSES & PERMITS	660
DUES & SUBSCRIPTIONS	15,681
MGMT CO ALLOCATION	839
TRUST/FRANCHISE/CONTRIB/ETC	(5,395)
Less: Public Relations Expense	(14,109)
Non-allowable advertising	(20,991)
Yellow page advertising	(6,527)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,139

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,081
RELATED PARTY	8,522
Seminar Expense	
	5,827
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,430

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	06/2001	$ 9,907	3	$ 1,652	$ 3,302	$ 3,302	$ 1,651	$	$	$	$	$
2	PAINT/DECORATING	06/2002	2,840	3		473	947	947	473				
3	PAINT/DECORATING	06/2003	9,437	3			1,572	3,146	3,146	1,573			
4	PAINT/DECORATING	06/2004	4,105	3				684	1,368	1,368	685		
5													
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18													
19													
20	TOTALS		$ 26,289		$ 1,652	$ 3,775	$ 5,821	$ 6,428	$ 4,987	$ 2,941	$ 685	$	$

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. HEALTHCARE ASSOC. - $8820**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,888** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees